Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TERRY BEAL, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name

LAMAR CISD

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-11-2416-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial of the charge made the basis of this medical fee dispute. Please note that the only issue requested on the DWC32 was Impairment Rating. No controversy existed on the date of MMI."

Response Submitted by: Pappas & Suchma, P.C., P.O. BOX 66655, Austin, Texas 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2010	99456-W5-WP	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 8, 2010
   - 01 – The Charge for the procedure exceeds the amount indicated in the fee schedule.
   - TW1 – Fee Schedule

   Explanation of benefits dated March 4, 2011
   - W1:01 – Workers Compensation State Fee Schedule Adjustment
   - RC 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
   - T193: T193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - T193 - No additional reimbursement allowed after review of appeal/reconsideration.
   - W1: TW1 – Workers Compensation State Fee Schedule Adjustment.
   - TW1 – Fee Schedule
   - COMMENT: PER EES-14 Only IR WAS REQUESTED, NOT MMI.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a DD examination. According to the Division's EES-14, the requested service was to determine an Impairment Rating (IR) and extent of the employee's compensable injury. The requestor billed for assignment of MMI which was not requested. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbosacral (spinal region) is $150.00.
2. The respondent reimbursed $300.00 for the IR. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 27, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.